TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
JEFERY POTTER DC

Respondent Name
SENTRY CASUALTY COMPANY

MFDR Tracking Number
M4-15-4198-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
AUGUST 27, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "SERVICES WERE RENDERED IN CONJUCTION WITH THE AUTHORIZATION. THE SERVICES WERE MEDICALLY NECESSARY AND DOCUMENTED IN THE RECORDS PROVIDED TO YOU."

Amount in Dispute: $408.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider's request was not datestamped [sic] as received by DWC MRD until 8/24/15 [sic]. Consequently, it is not timely as to the DOS at issue per Rule 133.307(c)(I)(A). The provider has waived its right for MFDR. Please dismiss."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 26, 2015	99212-25, 98940 and 98943	$178.00	$0.00
August 26, 2015	97140-59-GP, 97110-GP-59, 97530-GP-59 and 97112-GP-59	$230.00	$127.14
TOTAL		$408.00	$127.14

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets out the general Medical Dispute Resolution guidelines.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedure for Medical Dispute Resolution of Medical Necessity Disputes.

Issues

1. Does the medical fee dispute referenced above contain information/documentation to support the denial of unnecessary medical for CPT Codes 99212-25, 98940 and 98943?
2. What is the dispute process for resolving medical necessity denials?
3. What is the dispute sequence?
4. What are the filing requirements after the resolution of a medical necessity denial?
5. Are the disputed CPT Codes 99212-25, 98940 and 98943 eligible for Medical Fee Dispute Resolution review?
6. Did the requestor waive the right to medical fee dispute resolution for CPT Codes 97140-59-GP, 97110-GP-59, 97530-GP-59 and 97112-GP-59?
7. Did the requestor obtain preauthorization for disputed CPT Codes 97140-59-GP, 97110-GP-59, 97530-GP-59 and 97112-GP-59?
8. Did the requestor meet the requirements of 28 Texas Administrative Code §134.203(b)(1)?
9. Is the requestor entitled to reimbursement for CPT Codes 97140-59-GP, 97110-GP-59, 97530-GP-59 and 97112-GP-59?

Findings

1. Review of the submitted documentation finds that the medical fee dispute referenced above contains information/documentation that indicates that there are **unresolved** issues of medical necessity for CPT Codes 99212-25, 98940 and 98943.
2. **Resolution of a Medical Necessity Dispute.** The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under ***Health Care Providers or their authorized representatives.***
3. **Notice of Dispute Sequence.** 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding…medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding…medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021.
4. The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals.
5. As a result, due to the unresolved medical necessity issues, CPT Codes 99212-25, 98940 and 98943 are not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.308.

   The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. This dismissal for CPT Codes 99212-25, 98940 and 98943 is based upon a review of all the evidence presented by the parties in this dispute. Even though not all the evidence was discussed, it was considered. The Division finds that CPT Codes 99212-25, 98940 and 98943 are not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307.
6. The requestor seeks resolution of CPT Codes 97140-59-GP, 97110-GP-59, 97530-GP-59 and 97112-GP-59 rendered on August 26, 2014.

   28 Texas Administrative Code §133.307(c) (1)(A), states, "A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

   The date of the services in dispute is August 26, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on August 27, 2015. The Division finds that date of service, August 26, 2014 was filed timely and in accordance with 28 Texas Administrative code

§133.307(c) (1)(A), as a result, the dispute CPT Codes 97140-59-GP, 97110-GP-59, 97530-GP-59 and 97112-GP-59 will be reviewed pursuant to the applicable rules and guidelines.

7. 28 Texas Administrative Code 134.600 (p)(5) states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services..."

   28 Texas Administrative Code 134.600 (c)(1)(B) states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur... (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

   The requestor submitted documentation to support that preauthorization was obtained for the disputed CPT Codes 97140-59-GP, 97110-GP-59, 97530-GP-59 and 97112-GP-59, as a result, the insurance carrier's denial of medical necessity is unsupported and the disputed services are reviewed pursuant to the applicable rules and guidelines.

8. 28 Texas Administrative Code 134.203(b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The Division completed NCCI edits to identify potential edit conflicts that would affect reimbursement. The following was identified:

   "Per CCI Guidelines, Procedure Code 97530 [THERAPEUT ACTVITY DIRECT PT CONTACT EACH 15 MIN] has a CCI conflict with Procedure Code 97140 [MANUAL THERAPY TQS 1/> REGIONS EACH 15 MINUTES]/]. Review documentation to determine if a modifier is appropriate."

   The requestor appended modifier -59 to CPT Code 97530. The *CPT Manual* defines modifier 59 as follows: "**Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25." The documentation submitted by the requestor does not meet the documentation requirements for appending modifier-59, as a result reimbursement for CPT Code 97530-GP-59 cannot be recommended.

   No edit conflicts were identified for CPT codes 97110, 97112 and 97140 as a result reimbursement is recommended per 28 Texas Administrative Code 134.203 (c)."

   Review of the CMS MLN matters # MM7050 states in pertinent part, "Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The Centers for Medicare & Medicaid Services (CMS) is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment for the PE for services furnished in office settings and other non-institutional settings and at 75 percent payment for the PE services furnished in institutional settings. The reduction applies to the HCPCS codes contained on the list of "always therapy" services that are paid under the MPFS, regardless of the type of provider or supplier that furnishes the services (e.g. hospitals, Home Health Agencies (HHAs), and Comprehensive Outpatient Rehabilitation Facilities (CORFs), etc.). The MPPR applies to the codes on the list of procedures included with CR7050 as Attachment 1. CR7050 is available at http://www.cms.gov/Regulations-and-Guidance/ Guidance/Transmittals/downloads/R826OTN.pdf on the CMS website. Note that these services

are paid with a non-facility PE. The current and proposed payments are summarized below in the following example based on the 75 percent reduction for institutional settings."

The disputed physical therapy codes; 97110-GP-59, 97112-GP-59 and 97140-GP-59 are identified on the "List of Therapy Procedures Subject to the Multiple Procedure Payment Reduction" therefore subject to the Multiple Procedure Payment Reduction (MPPR). Reimbursement is therefore calculated according to the CMS MPPR payment policy.

9. 28 Texas Administrative Code 134.203(c) states in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

   Procedure code 97140, service date August 26, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 0.43602. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 1.004 is 0.4016. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.939 is 0.00939. The sum of 0.84701 is multiplied by the Division conversion factor of $55.75 for a MAR of $47.22. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $36.03.

   Procedure code 97112, service date August 26, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 0.4563. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 1.004 is 0.48192. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.939 is 0.00939. The sum of 0.94761 is multiplied by the Division conversion factor of $55.75 for a MAR of $52.83. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $52.83.

   Procedure code 97110, service date August 26, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 0.4563. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 1.004 is 0.44176. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.939 is 0.00939. The sum of 0.90745 is multiplied by the Division conversion factor of $55.75 for a MAR of $50.59. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $38.28.

   The Division finds that the requestor is entitled to reimbursement in the amount of $127.14 for disputed 97110-GP-59, 97112-GP-59 and 97140-GP-59.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $127.14.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $127.14 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		September 24, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.